

Complete Summary

GUIDELINE TITLE

Behavioral counseling in primary care to promote physical activity: recommendation and rationale.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Behavioral counseling in primary care to promote physical activity: recommendation and rationale. Ann Intern Med 2002 Aug 6; 137(3): 205-7.

COMPLETE SUMMARY CONTENT

SCOPE
 METHODOLOGY - including Rating Scheme and Cost Analysis
 RECOMMENDATIONS
 EVIDENCE SUPPORTING THE RECOMMENDATIONS
 BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
 IMPLEMENTATION OF THE GUIDELINE
 INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
 CATEGORIES
 IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Sedentary behavior

GUIDELINE CATEGORY

Counseling
 Prevention

CLINICAL SPECIALTY

Family Practice
 Internal Medicine
 Nursing
 Nutrition
 Obstetrics and Gynecology
 Preventive Medicine
 Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations on counseling by primary care physicians to promote physical activity and the supporting scientific evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, second edition

TARGET POPULATION

Patients in primary care settings

INTERVENTIONS AND PRACTICES CONSIDERED

Behavioral counseling

MAJOR OUTCOMES CONSIDERED

- The outcome of primary interest was the proportion of patients who met the Healthy People 2010 goal* in the 'long-term', defined in the guideline's companion evidence review as at least 6 months after randomization

*30 minutes of moderate activity on 5 or more days per week or 20 minutes of vigorous activity 3 or more times per week

- When that outcome was not available, mean changes in activity levels were recorded
- If reported, short-term results were also recorded

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Search strategy

The Oregon Health and Science University Evidence-based Practice Center (EPC), technical contractors to the U.S. Preventive Services Task Force (USPSTF), searched the Cochrane Database of Systematic Reviews and Registry of Controlled

Trials through March 2002 using the term "physical activity" and found abstracts for 49 reviews and 966 controlled trials. They searched the MEDLINE and HealthStar databases from 1994 to March 2002, using the MeSH terms "exercise," "physical fitness," "counseling," "patient education," and "health education," and found 549 abstracts. Experts and reference lists of pertinent articles provided an additional 145 references.

Selection of studies

In consultation with members of the U.S. Preventive Services Task Force, the Evidence-based Practice Center took the middle ground of including all controlled clinical trials in which some components of the intervention were performed by the patient's primary care clinician (nurse practitioner, nurse, physician, or physician assistant). To describe the clinician's role as well as other components of interventions consistently, the Evidence-based Practice Center used an abstraction tool developed by the Behavioral Counseling Work Group of the current the U.S. Preventive Services Task Force. The tool is based on the practical "5-A" framework (Assess, Advise, Agree, Assist, and Arrange/Adjust) originally developed to describe the elements of brief provider tobacco-cessation interventions. The Evidence-based Practice Center limited the review to trials published since the last the U.S. Preventive Services Task Force review (1994 and later) that reported behavioral outcomes of an intervention to increase physical activity.

See "Companion Documents" including:

- Eden KB, Orleans CT, Mulrow CD, Pender NJ, Teutsch SM. Counseling by clinicians: does it improve physical activity: a summary of the evidence for the U. S. Preventive Services Task Force. *Ann Intern Med* 2002 Aug 6; 137(3):208-15.
- Whitlock EP, Orleans CT, Pender NJ, Allan J. Evaluating primary care behavioral counseling interventions: an evidence-based approach. *Am J Prev Med* 2002; 22(4):267-84.

NUMBER OF SOURCE DOCUMENTS

8 (7 randomized controlled trials, 1 non-randomized controlled trial) met the inclusion criteria

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr; 20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute-University of North Carolina at Chapel Hill (RTI-UNC) Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Data Synthesis

A single EPC reviewer abstracted information about setting, patient participants, providers, interventions, adherence, and outcomes. At least two reviewers summarized the quality of each study using criteria developed by the current USPSTF. The internal validity of each trial was rated "good," "fair," or "poor."

EPC staff summarized the design, quality, and results of each included trial in an evidence table, focusing on the magnitude of change in and duration of physical activity. They examined the consistency of results among studies and the relationship between effects and specific components of the interventions, discussing separately studies that compared an intervention with usual care and those that compared two interventions.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the

recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr; 20(3S): 21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center (EPC) and the Agency for Healthcare Research and Quality (AHRQ) send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and U.S. Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

This report was distributed for review to 13 outside experts and representatives of professional societies and federal agencies.

Recommendations of Others. Recommendations for behavioral counseling in primary care to promote physical activity from the following groups were discussed: the Canadian Task Force on Preventive Health Care, U.S. Department of Health and Human Services, U.S. Centers for Disease Control and Prevention, U.S. National Center for Education in Maternal and Child Health, American Academy of Family Physicians, American Academy of Pediatrics, the American Heart Association, the American College of Obstetricians and Gynecologists, and the U.S. Task Force on Community Preventive Services.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

- The U.S. Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against behavioral counseling in primary care settings to promote physical activity. [I recommendation]

The U.S. Preventive Services Task Force found insufficient evidence to determine whether counseling patients in primary care settings to promote physical activity leads to sustained increases in physical activity among adult patients. Controlled trials of physical activity counseling in adult primary care patients were of variable quality and had mixed results. There were no completed trials with children or adolescents that compared counseling with usual care practices. Data on the feasibility and potential harms of routine physical activity counseling in primary care settings are limited. As a result, the U.S. Preventive Services Task Force could not determine the balance of potential benefits and harms of routine counseling to promote physical activity in adults. The U.S. Preventive Services Task Force reviewed only the literature on the effectiveness of primary care counseling to promote physical activity. It did not review the evidence for the effectiveness of physical activity to reduce chronic disease morbidity and mortality, which has been well documented in other recent reviews, or review evidence of counseling in other settings, or review evidence of counseling in other settings.

Clinical Considerations

- Regular physical activity helps prevent cardiovascular disease, hypertension, type 2 diabetes, obesity, and osteoporosis. It may also decrease all-cause morbidity and lengthen life-span.
- Benefits of physical activity are seen at even modest levels of activity, such as walking or bicycling 30 minutes per day on most days of the week. Benefits increase with increasing levels of activity.
- Whether routine counseling and follow-up by primary care physicians results in increased physical activity among their adult patients is unclear. Existing studies limit the conclusions that can be drawn about efficacy, effectiveness, and feasibility of primary care physical activity counseling. Most studies have tested brief, minimal, and low-intensity primary care interventions, such as 3 to 5 minute counseling sessions in the context of a routine clinical visit.
- Multi-component interventions combining provider advice with behavioral interventions to facilitate and reinforce healthy levels of physical activity appear the most promising. Such interventions often include patient goal setting, written exercise prescriptions, individually tailored physical activity regimens, and mailed or telephone follow-up assistance provided by specially trained staff. Linking primary care patients to community-based physical activity and fitness programs may enhance the effectiveness of primary care clinician counseling.
- Potential harms of physical activity counseling have not been well defined or studied. They may include muscle and fall-related injuries or cardiovascular events. It is unclear whether more extensive patient screening, certain types of physical activity (e.g., moderate vs. vigorous exercise), more gradual increases in exercise, or more intensive counseling and follow-up monitoring will decrease the likelihood of injuries related to physical activity. Existing studies provide insufficient evidence regarding the potential harms of various activity protocols, such as moderate compared with vigorous exercise.

Definitions:

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The US Preventive Services Task Force found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Counseling

The U.S. Preventive Services Task Force (USPSTF) found 8 fair to good quality controlled trials (7 randomized, and 1 not randomized) and 5 poor quality trials that addressed whether counseling involving a primary care clinician improved physical activity. Most trials involved sedentary adults. Most studies directly tested whether physical activity counseling in the primary care setting was beneficial, although some were designed to test whether educating clinicians to provide physical activity counseling was beneficial. Some interventions addressed multiple behaviors (smoking, alcohol use, and sedentary behaviors). Reports often provided limited detail regarding counseling interventions, and in several studies, delivery or receipt of the intervention was not confirmed. Some trials studied selected patient and/or provider populations. Most fair to good quality trials followed participants for at least 6 to 12 months and had follow-up rates of >85%. Few studies included efforts to verify or validate self-reported behavioral outcomes.

The six trials of fair to good quality that compared physical activity counseling protocols to usual care provided mixed results. Of the three trials reporting short-term (<6 months) behavioral outcomes, one found significantly higher physical activity levels in the intervention group, and two found no differences between intervention and control groups in activity levels. Of the six trials that reported long-term (≥ 6 months) behavioral outcomes, two found significantly higher

physical activity levels in the intervention group, and four found no differences between intervention and control groups in levels of physical activity.

Two fair to good quality randomized trials compared two or more different interventions aimed at increasing physical activity. In one, patients receiving advice and an exercise prescription were significantly more active at 6 weeks than those receiving only advice. The second trial compared increasingly intensive interventions delivered over a 2 year period. The intervention groups in this study included: physician advice alone totaling about 18 minutes; physician advice plus moderate intensity health educator behavioral counseling totaling about 3 hours; and physician advice plus more intensive health educator behavioral counseling totaling about 9 hours. The study did not find any significant overall group differences in self-reported physical activity or cardiorespiratory fitness at 6, 12, and 24 months. However, women in the most intensively counseled group reported significantly higher energy expenditure at 6 months than women in the moderate intensity counseling and advice-only groups, and women in the moderate and intensive counseling groups were documented to have significantly higher fitness levels at 24 months (measured by VO_2 max) than women in the advice-only group.

The U.S. Preventive Services Task Force found no completed studies examining effectiveness of physical activity counseling for children or adolescents that compared treatment to a usual care control. Several such studies are in progress.

POTENTIAL HARMS

Potential Adverse Effects of Counseling

Only one of the trials reviewed, monitored, and reported potential harms related to physical activity counseling. This trial, in which initially sedentary program participants between 35 and 75 years of age chose either moderate or vigorous activity, found an approximate 60% rate of musculoskeletal injuries and 30% rate of symptoms that may represent cardiovascular problems (chest pain, difficulty breathing, dizziness or loss of consciousness) over two years, with no significant differences between groups randomized to physician advice, physician advice plus behavioral counseling, or physician advice plus more intensive counseling. As this trial did not have a control group that received currently recommended care, it is difficult to ascertain whether any of the reported harms were directly due to physical activity counseling.

Widespread implementation of counseling could increase demand on clinical staff. However, available evidence suggests that clinicians may view counseling as a benefit to their practices. In a large randomized controlled trial, 63% of participating clinicians reported that counseling caused little to no increase in the length of the routine visit, 33% percent reported there was some increase, and only 4% complained of a substantial increase in the length of patient visits. Most clinicians (83%) felt that offering physical activity counseling was a benefit to the clinic.

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the [Guide](#) ("Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach") - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force and Community Guide effort have conducted an audience analysis to further explore implementation needs. The [Put Prevention into Practice](#) initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of

U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

RELATED QUALITY TOOLS

- [Pocket Guide to Good Health for Adults](#)
- [A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach](#)

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Behavioral counseling in primary care to promote physical activity: recommendation and rationale. Ann Intern Med 2002 Aug 6; 137(3): 205-7.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2002 Aug 6)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Alfred O. Berg, MD, MPH, (Chair); Janet D. Allan, PhD, RN, CS, FAAN (Vice-chair); Paul S. Frame, MD; Charles J. Homer, MD, MPH; Mark S. Johnson, MD, MPH; Jonathan D. Klein, MD, MPH; Tracy A. Lieu, MD, MPH; Tracy C. Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J. Pender, PhD, RN, FAAN; Albert L. Siu, MD, MSPH; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H. Woolf, MD, MPH.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Counseling to promote physical activity. In: Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Also available from the [Annals of Internal Medicine Online](#) and the [National Library of Medicine's Health Services/Technology Assessment Text \(HSTAT\) Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Eden KB, Orleans CT, Mulrow CD, Pender NJ, Teutsch SM. Does counseling by clinicians improve physical activity? A summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med* 2002 Aug 6; 137(3): 208-15.

Electronic copies: Available from the [USPSTF Web site](#) and the [Annals of Internal Medicine Online](#).

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr; 20(3S): 13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr; 20(3S): 21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr; 20(3S): 36-43.
- Whitlock EP, Orleans CT, Pender NJ, Allan J. Evaluating primary care behavioral counseling interventions: an evidence-based approach. *Am J Prev Med* 2002; 22(4): 267-84.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following is also available:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the [Agency for Healthcare Research and Quality \(AHRQ\) Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the [AHRQ Web site](#).

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Copies also available in Spanish from the [USPSTF Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated on July 26, 2002. The information was verified by the guideline developer on July 30, 2002.

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The logo for FIRSTGOV, with "FIRST" in blue and "GOV" in red, and a small red star above the "I".

